CALIFORNIA DEPARTMENT OF
Mental Health

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January 12, 2001

TO: LOCAL MENTAL HEALTH DIRECTORS

SUBJECT: MODIFICATION OF THE ADULT PERFORMANCE OUTCOME SYSTEM

County and city mental health programs have invested considerable time and effort toward providing performance outcome data to the State Department of Mental Health (DMH), and we are very appreciative of these contributions. As the various age-specific performance outcome systems were developed, the California Mental Health Directors Association (CMHDA), the California Mental Health Planning Council (CMHPC), and DMH agreed that the only way to ensure the effectiveness of our outcomes systems would be to view them as continually in a process of evolution. As a result, it was agreed that staff would continually examine potentially more cost-effective and efficient instruments and methodologies. After evaluating the data collected during a full year of implementation of the Adult Performance Outcome System (APOS) and after consultation with representatives of both the CMHDA and CMHPC, two changes relating to the APOS have been made as described below.

Summary

- Effective immediately, the Behavior and Symptom Identification Scale (BASIS-32) will no longer be required by the State for the APOS. Local mental health programs choosing to continue to use the BASIS-32 will need to contact the author regarding copyright issues.

- In an effort to help county and city programs gauge their success in administering the performance outcome instruments to their estimated target population, the DMH is planning to begin posting individual county and city program reporting rates on its Information Technology Web Services (ITWS) secure web site in the near future.

Background

Several years ago, DMH embarked on a collaborative effort with the CMHDA and the CMHPC to develop California's mental health performance outcomes system. This endeavor was in response to 1991 "realignment" legislation requiring counties to provide

data on performance outcome measures to DMH and was part of a nationwide trend toward accountability.

To date, the data collected from our systems have been used to help obtain community mental health block grant funds through the SAMHSA block grant as well as encourage the expansion of Children's Systems of Care statewide. The Department of Finance, as well as the Legislature, have communicated that they are increasingly interested in using these data for assessing the effectiveness of the statewide mental health system. Additionally, the State Quality Improvement Committee is beginning to use this information.

The APOS was implemented a little over one year ago after a pilot test which examined a wide variety of potential instruments. In addition to a face sheet which collects demographic information that is critical to linking the outcome data to other departmental data systems, the current adult system includes the following instruments: the BASIS-32, a quality of life instrument, and the Mental Health Statistics Improvement Program Consumer Survey (MHSIP). These instruments are self-administered and, except for the BASIS-32 (and the QL-SF if counties choose to use it rather than the California Quality of Life Survey), they are all in the public domain. Two major concerns have been expressed about the APOS. First, very little information is collected from the clinician's perspective. In the current children's system, clinician ratings have been the most useful when evaluating overall client functioning and symptomatology. The second, and perhaps more important concern in the near term, is related to using client self-reports of symptoms and functioning for the purpose of reporting outcomes (e.g., the BASIS-32, which represents the client's perspective on symptoms and functioning.)

After an evaluation of information provided during this first year of implementation, it has become evident that the BASIS-32 is not working as expected. It has become apparent that, for a wide variety of reasons, clients significantly underreport their symptoms and impairments. Thus, data appear to indicate that consumers are experiencing very few functional impairments. As a result, using the data to demonstrate effectiveness of services is problematic. If clients come into services perceiving that they have little or no impairment, there is little room to document improvement. It is even possible that as clients gain additional insight into their illness, they may report increased impairments over time—an effect that is difficult to explain to constituents who expect that people should improve after receiving services. Therefore, while client perception of symptoms and functioning may be important information for the treating clinician, it does not seem to be particularly useful for assessing program outcomes. While the BASIS-32 has been found to be less useful than expected, the MHSIP has been found to be more useful. The State

Quality Improvement Committee is using MHSIP results as an indicator of county performance and has not felt that the BASIS-32 provided the information it wanted.

An additional problem related to the BASIS-32 is that, although the state believed that it had purchased an unlimited site license for counties when it paid the Medical Outcomes Trust (a group that handled licensing for the BASIS-32) approximately $10,000, the author is now requiring the payment of an annual fee for its continued usage.

After consulting with the CMHPC and representatives of the consumer community as well as the CMHDA leadership, the decision has been made that we are not obtaining enough value at the quality management or "system" level to continue requiring the BASIS-32 in light of the increased costs. Effective immediately, local mental health programs will no longer be required to administer and report data for the BASIS-32. In order to include symptom and functional information that would otherwise be missing, the current adult face sheet may be revised at a later date using the older adult face sheet (now being piloted) as a model.

County Data Reporting

DMH Research and Performance Outcome Development staff review on a regular basis the performance outcome data that counties submit. One of their tasks is to evaluate the extent to which each county is submitting data on all of the individuals who are considered to be a part of the performance outcomes target population. This target population is generally defined as those clients who have received services for 60 days or longer (excluding those clients who only receive medications services) and excluding those clients who are only seen in the county's individual provider network.

It has become evident that in many counties the number of records that have been submitted is well below what would be expected given estimates of their target populations. Some counties, on the other hand, have done a very good job at submitting complete data sets. DHM recognizes that collecting and reporting the data is no small task and would like to provide as much support as possible in helping counties and city mental health programs gauge their performance in this matter. Therefore, in the near future DMH will begin posting on its secure ITWS internet server a table listing each county, its estimated target population, the number of performance outcome records that each county has submitted, and the percent of the estimated target population that the county is covering.

If you have any general questions related to these changes, please direct them to the attention of Jim Higgins, Manager of the Research and Performance Outcome Development Unit, at (916) 653-3517 or e-mail jhiggins@dmhhq.state.ca.us.

Again, DMH would like to thank county staff for their effort and commitment to the successful implementation of these systems.

Sincerely,

CAROL S. HOOD
Deputy Director

cc: Adult Performance Outcome Contacts
California Mental Health Planning Council